State of California—Health and Human Services Agency

Department of Public Health

California Perinatal Hepatitis B Prevention Program

Confidential HBsAg+ Case/Household Management Report

Mail to: Perinatal Hepatitis B Prevention Program
Immunization Branch
California Department of Public Health
850 Marina Bay Parkway
Building P, 2nd Floor
Richmond, CA 94804
OR
Fax to: (510) 620-3949

☐ New Report ☐ Update ☐ In-State Transfer ☐ Close ☐ Out-of-State Transfer

MOTHER

1. **Case/Household Identification No.** ___-___-___-____ (county of origin)
County mm yy

2. **County:** _____

3. **Case/Household Identification No.** ___-___-___-____ (transfer county)
County mm yy

4. **Date this report initiated** ___/___/_____
mm dd yyyy

5. **Name:** _____
Last First MI

6. **SSN** ____-____-____
if available

7. **City** _____ 8. **Zip** _____

9. **Mother's date of birth** ___/___/_____
mm dd yyyy

10. **Mother's age when screened** _____

11. **EDD** ___/___/_____
mm dd yyyy

12. **Is this the first case/household management report submitted to CA Perinatal Hep. B Prog. on this mother?**
1☐ Yes 2☐ No 9☐ Unknown

13. **Source of HBsAg+ report**
1☐ Laboratory 4☐ Delivery hospital
2☐ Prenatal care provider 5☐ Other (Specify):____
3☐ Infant's care provider 9☐ Unknown

14a. **Was HBsAg+ known before this pregnancy?**
1☐ Yes 2☐ No 9☐ Unknown

b. If "Yes", was this discovered in connection with a previous pregnancy?
1☐ Yes 2☐ No 9☐ Unknown

15a. **When was HBsAg+ test done?**
1☐ Pre-pregnancy 2☐ At delivery
3☐ During pregnancy 9☐ Other/Unk

b. If "During pregnancy", enter month of pregnancy :____

16. **Planned payment for delivery?**
1☐ Medi-Cal 4☐ Self-pay
2☐ Other/Govt. 3rd party payer 5☐ Low income: _____
3☐ Private 3rd party payer 9☐ Other/Unk: _____

17. **Planned delivery hospital?**
1☐ Public hospital 3☐ Outside of hospital
2☐ Private hospital 9☐Unknown

18a. **Country of mother's birth**
1☐U.S.A. 2☐ Other (Specify): _____ 9☐ Unknown

b **If "Other", Is she a refugee?** 1☐ Yes 2☐ No 9☐ Unknown

Answer all ethnicity and race questions:

19a. **Ethnicity:**
1☐ Hispanic 2☐ Non-Hispanic 9☐ Unknown

19b. **Race: (Check all that apply)**
1☐ White 2☐ Black 3☐ Amer. Indian/Alaskan Native
4☐ Asian* 5☐ Pacific Islander* 6☐ Other/Unspecified

c. ***If Asian, please check all that apply:**
1☐ Chinese 2☐ Japanese 3☐ Korean
4☐ Filipino 5☐ Asian Indian 6☐ Cambodian (non-Hmong)
7☐ Thai 8☐ Laotian (non-Hmong) 9☐ Vietnamese (non-Hmong)
10☐ Hmong 11☐ Other Asian:____

d. ***If Pacific Islander, please check all that apply:**
1☐ Guamanian 2☐ Samoan
3☐ Native Hawaiian 4☐ Other Pacific Islander:
_____

20. **Initial submit date:**
___/___/_____
mm dd yyyy

21. **Close date:**
___/___/_____
mm dd yyyy

INFANT(S)

1. **Case/Household Identification No**. ___ – ___ – ___ – ____ (county of origin)
County mm yy

2. **Case/Household Identification No**. ___ – ___ – ___ – ____ (transfer county)
County mm yy

3. **This pregnancy resulted in a: (Check all that apply)**
   a. Live birth → Number of live infant(s) born (1,2 etc): _____
   b. Fetal death → Number of fetal deaths: _____
   c. Miscarriage or abortion → ☐(check box if 'yes')

4. **Actual source of payment for delivery?**
   1☐ Medi-Cal 4☐ Self-pay
   2☐ Other/Govt. 3rd party payer 5☐ Low income: _____
   3☐ Private 3rd party payer 9☐ Other/Unk: _____

5. **Actual delivery hospital?**
   1☐ Public hospital 3☐ Outside of hospital
   2☐ Private hospital 9☐ Unknown

Infant # ___ If only one live infant, enter "1". If two or more live infants, attach additional page for each infant, assign the same case/household ID number on this form, number each infant accordingly (1, 2, 3 etc) and complete the infant section only.

6. **Name:** _____ 7. **Birth date:** ___/___/____
Last First MI mm dd yyyy

8. **Sex:** 1☐Male 2☐Female

Immunization Record:

9. **HBIG** a. ☐ Not given
   b. Age when given (hours) _____
   c. Date when given ___/___/____ (mm dd yyyy)

10. **Hep B Vac1** a. ☐ Not given
   b. Age when given (hours) _____
   c. Date when given ___/___/____ (mm dd yyyy)

11. **Hep B Vac2** Date when given ___/___/____ (mm dd yyyy)

12. **Hep B Vac3** Date when given ___/___/____ (mm dd yyyy)

13. **Hep B Vac4** (If applicable) Date when given ___/___/____ (mm dd yyyy)

Lost to Follow-up (for mother and infant):

19. If infant does not complete the Hep B vaccine series or post-vaccination serology testing, check all of the reasons that apply.
   a. ☐ Infant completed Hep B series but was lost before serology testing was completed
   b. ☐ Infant diagnosed with acute Hep B before vaccine series was completed
   c. ☐ Infant could never be located
   d. ☐ Located mother/household but later lost to follow-up
   e. ☐ Infant moved or transferred to another county within the state for follow-up and don't know whether vaccination series was completed or not
   f. ☐ Infant moved out of the state
      new address: _____
      _____
   g. ☐ Infant moved out of the country
   h. ☐ Compliance problem with family
   i. ☐ Infant died
   j. ☐ Other (specify): _____

Post-Vaccination Follow-up Serology Record:

14. a. **HBsAg test done?** 1☐Yes 2☐No 9☐Unk
   If 'Yes': b. Date done ___/___/____ (mm dd yyyy)
   c. Result: 1☐Pos 2☐Neg 9☐Unk

15. a. **Anti-HBs test done?** 1☐Yes 2☐No 9☐Unk
   If 'Yes': b. Date done ___/___/____ (mm dd yyyy)
   c. Result: 1☐Pos 2☐Neg 9☐Unk

Second Series Immunization and Repeat Post-Vaccination Serology Record:

16. a. **If 'Neg', did infant receive a 2nd series of vaccine?**
   1☐Yes 2☐No 9☐Unk
   b. **Hep B Vac1** ___/___/____ (mm dd yyyy)
   c. **Hep B Vac2** ___/___/____ (mm dd yyyy)
   d. **Hep B Vac3** ___/___/____ (mm dd yyyy)

17. a. **Was HBsAg test done after 2nd series?**
   1☐Yes 2☐No 9☐Unk
   b. Date done ___/___/____ (mm dd yyyy)
   c. Result: 1☐Pos 2☐Neg 9☐Unk

18. a. **Was Anti-HBs test done after 2nd series?**
   1☐Yes 2☐No 9☐Unk
   b. Date done ___/___/____ (mm dd yyyy)
   c. Result: 1☐Pos 2☐Neg 9☐Unk

CONTACTS

1. **Case/Household Identification No.** ___ – ___ – ___ – ____ (county of origin)
County mm yy

2. **Case/Household Identification No.** ___ – ___ – ___ – ____ (transfer county)
County mm yy

3. **All Household Contacts**

a. _____ Total number of household contacts identified (a = b+c+d+j+k)

b. _____ Number already known to be chronically infected or immune due to prior infection of Hep B

c. _____ Number previously immunized

d. _____ Number seroscreened for Hep B markers (usually anti-HBc)

e. _____ Of those seroscreened, number age ≤ 5 years

f . _____ Of those seroscreened, number age ≥ 6 years

g. _____ Of those seroscreened, number found to be already infected or immune

h. _____ Of those seroscreened, number found to be susceptible (i.e. negative for Hep B markers)

i. _____ Of those found to be susceptible, number vaccinated

j. _____ Number vaccinated without screening

k. _____ Number lost to follow-up

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4. **Household Contacts Receiving Immunization (list in any order)**
Please enter the codes in ( ) into the spaces below.

	a. Name (optional)	b. Age: 0-5 yrs (1); 6-21 yrs (2); ≥22 yrs. (3)	c. Hep B Vac 1 given? Yes (1); No (2); Unk (9)	d. Hep B Vac 2 given? Yes (1); No (2); Unk (9)	e. Hep B Vac 3 given? Yes (1); No (2); Unk (9)
Contact 1					
Contact 2					
Contact 3					
Contact 4					
Contact 5					
Contact 6					

5. **Lost to Follow-Up**

If any of the household contacts listed above does not complete the 3-dose series, check all of the reasons that apply.

a. ☐ Contact(s) located but later lost to follow-up
b. ☐ Contact(s) found to be already infected or immune after series was started
c. ☐ Contact(s) moved to another county within the state for follow-up and don't know whether vaccination series was completed or not
d. ☐ Contact(s) moved out of the state
e. ☐ Contact(s) moved out of the country
f. ☐ Contact(s) died
g. ☐ Compliance problem with family
h. ☐ Other (specify):_____

1 **Case/Household Identification No.** ___ – ___ – ___ – ____ (county of origin)
County mm yy

2 **Case/Household Identification No.** ___ – ___ – ___ – ____ (transfer county)
County mm yy

Optional worksheet (Do not send to State)

Name_____

Household address(es)/phone(s)_____

_____

Translator needed? ☐YES ☐NO Mother's language_____

Staff person assigned to case/household_____ Delivery hospital_____

Provider type_____ Provider type_____

Physician name_____ Physician name_____

Clinic address(es)_____ Clinic address(es)_____

Phone(s)_____ Phone(s)_____

Infant(s)

Dates Doses Due/Given=

Name(s)	Date of Birth	HBIG/Vac #1	Vac #2	Vac #3	Vac 4	PVS*
1.		Due	Due	Due	Due	Due
		Given	Given	Given	Given	Given
2.		Due	Due	Due	Due	Due
		Given	Given	Given	Given	Given

*Post Vaccination Serology Testing

Household Contacts

Dates Doses Due/Given=

Name(s)	DOB	Sex	Date Referred	Serology Results	Vac #1	Vac #2	Vac #3	Notes
1.					Due	Due	Due	
					Given	Given	Given	
2.					Due	Due	Due	
					Given	Given	Given	
3.					Due	Due	Due	
					Given	Given	Given	
4.					Due	Due	Due	
					Given	Given	Given	
5.					Due	Due	Due	
					Given	Given	Given	
6.					Due	Due	Due	
					Given	Given	Given	